2010

Cross-System Environmental Scan

A Project of California FIRST

This report synthesizes information from each of California's 58 counties about some key characteristics of families in the child welfare system in need of substance abuse treatment and support. Characteristics of existing Dependency Drug Court Models have been mapped out in conjunction with key permanency and recovery benchmarks to provide a snapshot of where things are working well for families. The recommendations captured within will provide the basis for development of a California-specific 'best practice' approach for improving outcomes for children and their families, and for the California communities in which they live.

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DRAFT

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INTRODUCTION

As of March 31, 2007, there were approximately 80,000 children in foster care in California. Many experts assert that upwards of 80 percent of child welfare cases involve some level of substance use disorder. Of the 214,614 clients in substance use disorder treatment in 2006, 86,201 were parents of children 17 and younger, although it is unclear how many of these families were in the child welfare system. Preliminary estimates are that this project will result in sufficient expansion to serve 46,080 parent clients statewide. This estimate is derived from assuming that 80% (46,080) of the approximate 57,600 total parent clients statewide have a substance abuse issue as a primary barrier to reunification.[1]

California was selected to participate in the National Center on Substance Abuse and Child Welfare's (NCSACW)[2] program of In-Depth Technical Assistance (IDTA), which will help the lead entities to:

DEFINE THE THRESHOLD COMBINATION AND TIMING OF INTERVENTIONS, SUPERVISION, AND SUPPORTS NECESSARY IN EACH OF CALIFORNIA'S 58 COUNTIES TO ACHIEVE:

- **Earlier access to quality treatment;**
- **Better treatment completion rates;**
- **Higher reunification rates; and**
- **Reduction in re-entry cases;**

FOR THE FAMILIES IN EACH COUNTY THAT HAVE SUBSTANCE USE DISORDERS AS A PRIMARY BARRIER TO REUNIFICATION.

This initiative, which has been dubbed **California FIRST,** is led by The State of California's Administrative Office of the Courts, Department of Social Services, and Department of Alcohol and Drug Programs. The IDTA will support California's continuing efforts to meet the child welfare service benchmarks established by the Administration for Children, Youth and Families relating to safety, permanency and well-being, and the Substance Abuse and Mental Health Services Administration's benchmarks relating to recovery and wellness.

WHY DEPENDENCY DRUG COURTS?

California's Dependency Drug Courts (DDCs) have been identified by the lead entities for **California FIRST** as the most promising cross-system collaborative model for establishing a systemic statewide approach to achieving the stated goal. Currently, 52 DDCs exist in 33 jurisdictions statewide and are designed to directly address substance abuse, provide needed court supervision, incentives and sanctions, and coordinate with the dependency case with a focus on family reunification services. Most of these are intensive court programs with limited caseloads. However, several jurisdictions in California have developed methods to screen entire dependency caseloads for substance abuse and provide modified dependency drug court type services to large numbers of cases, with intensive dependency drug court services available to those who require the more intensive model.

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[1] 80,000 children in the dependency system; total number of parent clients = 72% of # of children per monthly statistics submitted by court-appointed attorneys; 72% * 80,000 = 57,600

2 The NCSACW is an initiative of the Department of Health and Human Services and jointly funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) and the Administration on Children, Youth and Families (ACYF), Children's Bureau's Office on Child Abuse and Neglect (OCAN).

Although DDCs have shown promising results in outcomes for parents and in children, as well as in cost efficiencies, they are often established as intensive court programs that have limited caseloads and a range of methodologies. The challenge is to expand this effective model, with modifications, to provide access to the DDC model to most, if not all, child welfare cases that have parental substance use disorders as a primary factor leading to juvenile court involvement and to ensure that dependency drug court programs statewide use effective and reasonably uniform practices to ensure equal access to, and quality of, justice.

Prior research suggests that DDCs support permanency and placement stability by reducing foster care reentries and by supporting timely reunification. By collectively engaging the court, the family and service agencies, they sustain and enhance permanency efforts across the life of the child welfare case. The well-being of children and families is supported by DDCs expansion of service options and by creating flexibility for services and supports to meet the needs of children and families, thus addressing the lack of services such as mental health and substance abuse treatment. Further, DDCs support California's efforts to ensure timely establishment of permanency goals and family involvement in case planning. DDCs are designed to enhance parental capacity to provide for their children's needs during and subsequent to reunification. Moreover, DDCs provide for an expanded, focused and individualized service array for participating families.

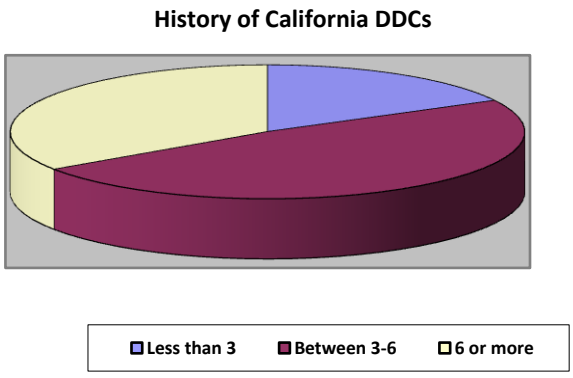
Survey Results on DDC Policies and Practices

Of the 52 Dependency Drug Courts currently in operation in California, 31 completed a survey administered by NCSACW in Spring 2009. Respondents ranged from judicial officers, program coordinators, agency administrators, clinical supervisors, and lead counselors. Responding counties included:

Alameda	Los Angeles	Sacramento	Santa Barbara	Riverside
Contra Costa	Mendocino	San Benito	Santa Clara	San Luis Obispo
Del Norte	Merced	San Bernardino	Santa Cruz	Tehama
El Dorado	Modoc	San Diego	Sierra	Tulare
Fresno	Nevada	San Francisco	Solano	Tuolumne
Lake	Orange	San Joaquin	Sonoma	Ventura

Length of Operation

The first Family Drug Court in the nation was established in Reno, Nevada in 1994. Four years later, California's first DDC was established by Judge Milliken in San Diego County. The most recently established DDC has been in existence for just over a year in Santa Barbara, indicating the wide range of history and experience that characterizes California's field of Dependency Drug Courts. The chart to the right depicts that range.



Program Model and Goals

California's DDC's largely identify the same goals for their programs:

Increase successful treatment completion rates	**94.6%**
Decrease recurrence of child abuse/neglect incidents	**91.9%**
Increase reunification rates	**89.2%**
Achieve early access to treatment	**89.2%**
Increase child safety	**83.8%**
Increase family recovery	**78.4%**
Timely permanency for children	**75.7%**

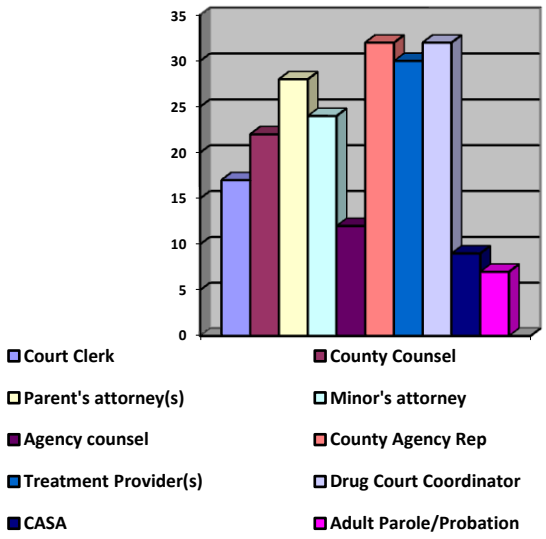
Other goals identified include: a) increasing employability; b) decreasing foster care placements, time that children spend in foster care, and foster care expenditures; c) increasing the number of infants that are born without positive toxicology screens; d) decreasing criminal justice system involvement; e) improving retention in treatment and long-term recovery; and f) improving stable housing and sober living conditions.

Currently, only a limited number of California DDCs (14.3% of those responding) have a bifurcated system of assigning all dependency cases involving substance abuse to a program that is similar to drug court, with more serious cases going to an intensive drug court if they don't succeed in the less intensive program. Another 14.3% say they are interested in this approach; however, the vast majority (65.7%) utilizes an approach where cases are assigned to either the specialized DDC track or the regular dependency court docket.

Program Leadership and Team Structure

Based on survey responses, the judicial officers that hear DDC cases in California are primarily judges (72.2%) and commissioners (19.4%), although a few programs have DDC cases heard by referees (2.8%) or pro tems (5.6%). In approximately 46% of these DDCs, only one judicial officer in the county's dependency court system hears DDC cases, whereas in just 14% of the programs, all of the judicial officers in the dependency court system hear DDC cases in addition to their regular caseload. In approximately 19% of these DDCs, only specific judicial officers hear DDC cases. For instance, in one county, the same judge hears the dependency case and the treatment review hearings, but if a case is contested, the trial or contested matter is heard by another bench officer.

In almost half of California's DDCs (48.6%), the same judicial officer dockets the dependency case and the dependency drug court case, while less than a third (29.7%) employ a model where different judicial officers docket the dependency case and the dependency drug court case. The remaining survey respondents indicated that they either utilized another model (5.4%) or were not sure which model they were using (16.2%).



These judicial officers provide the leadership for the collaborative cross-system teams that comprise the DDC team structure. The graphic on the right indicates the entities that are most often part of the DDC program team. DDC teams may also include: social workers, district attorneys, public defenders, public health nurses, alcohol and drug program case managers, mental health liaisons, domestic violence advocates, employment specialists, and FIRST 5 family partners. Approximately half (48.6%) of the programs surveyed have drug court coordinators that are court-based, with the other half of DDC programs employing coordinators elsewhere – primarily in the County Alcohol and Drug agency.

In addition to the multidisciplinary clinical/court teams described above, nearly 80% of the DDCs surveyed indicate that they also have a multidisciplinary policy team that is responsible for strategic planning and making policy and program-related decisions about the DDC. For 42% of these programs, the policy team is comprised of the same representatives as the clinical/court team. However, for 36% of the programs, the two teams are comprised of different players, with the policy team typically made up of higher level administrators from the various agencies as well as the presiding judge.

Program Eligibility Criteria, Participation and Timelines

Nearly half of survey respondents run a 12-month DDC program, and a full 40% extend to 18 months. A limited number (5.6%) operate for two years, and a similarly small percentage (8.3%) operate for a minimum of 3-6 months. Issues such as the need for residential treatment, number of children, and response to relapse episodes tend to influence program length in many cases.

For the majority (43.2%) of the California DDCs, participants enter and exit the program voluntarily. In one program, the DDC clients are admitted involuntarily for the first 90 days, and then given the option to continue on a voluntary basis. In a third of the programs surveyed, participants can enter voluntarily (provided they meet eligibility criteria), and in the case of one program, participants can request dismissal from the program, rather than have their participation terminated prior to graduation based on the decision of the program team. In some jurisdictions, participants in dependency court are given the option to enter the DDC or face jail sanctions. Others give participants a menu of treatment and program intensity options to choose from, where the level of court supervision varies.

Once admitted into the DDC, status review hearings, including legal hearings, are conducted more frequently than in the regular dependency court process. While 41% of survey respondents indicate that the frequency of hearings is based on which phase the client is in, 30% indicate that they conduct weekly hearings, 25% hold bi-weekly hearings, and 5% have monthly hearings.

We try to keep dependency case issues and visitation issues to a minimum but the judicial officer allows the participants to discuss their experiences.

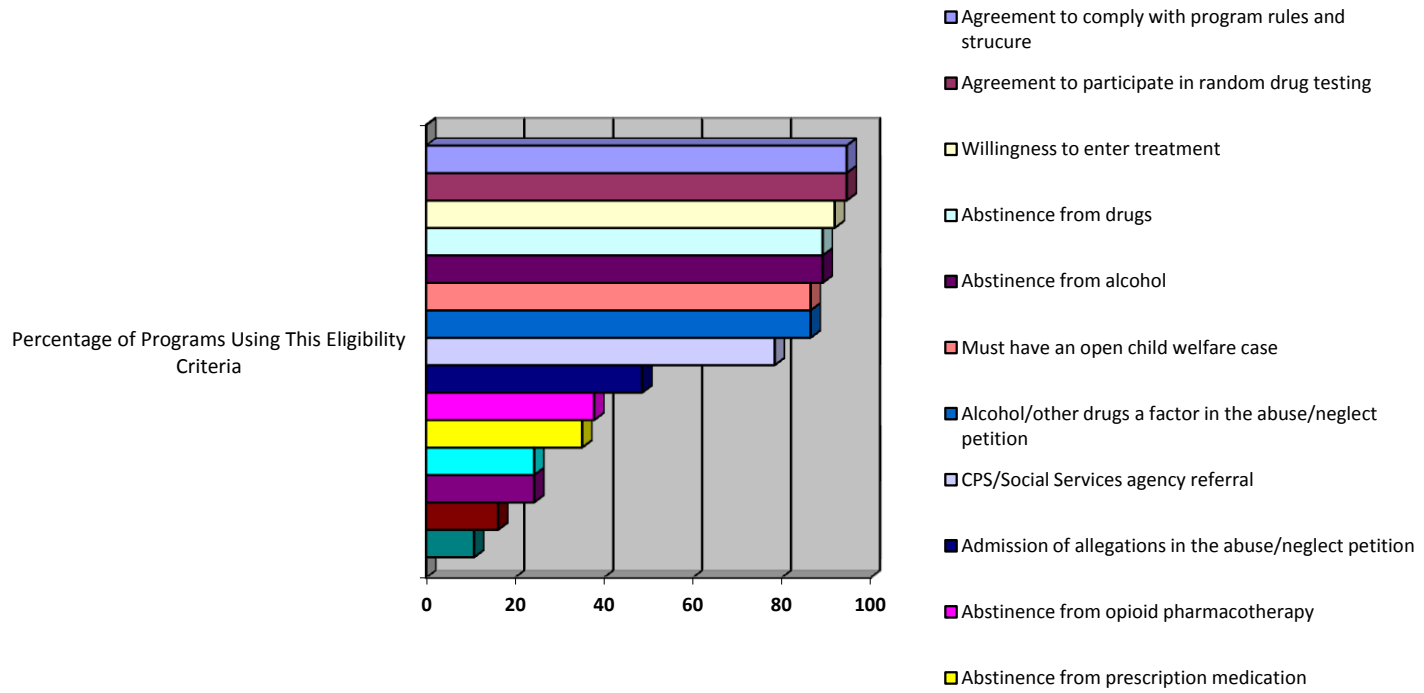
Issues that get addressed at these hearings vary from program to program, but it is notable that 100% of DDCs surveyed monitor the treatment needs of program participants and their progress in treatment. 60% of these programs address visitation issues in the child welfare case, and 51% address child placement decisions. A little over a third of the programs surveyed address a range of issues related to the dependency case processing. One respondent noted that their program "tries to limit treatment reviews to treatment issues and tries to keep legal issues for legal hearings". Other programs address issues beyond treatment and child dependency case issues, such as: school and work progress, criminal proceedings that clients may be involved in, family and marriage concerns, and health, housing, mental health, and child care needs.

Nearly 84% of survey respondents indicated that their programs adhere to the following "Ten Key Drug Court Components":

- A Steering Committee composed of key stakeholders to provide advice in the design and operation of the Treatment Drug Court. (81.1%)
- Integration of alcohol and other drug treatment services with justice system case processing. (91.9%)
- Use of a non-adversarial approach with prosecution and defense counsel promoting public safety while protecting participants' due process rights. (89.2%)
- Eligible participants are identified early and promptly placed in the drug court program. (91.9%)
- Provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services. (94.6%)
- Frequent staffing (team meetings), where each client's progress, strengths, obstacles, and options are discussed individually, and case plans are updated as needed. (94.6%)
- Abstinence is monitored by frequent alcohol and other drug testing. (94.6%)
- A coordinated strategy governs responses to participants' compliance. (91.9%)
- Ongoing judicial interaction with each participant. (100.0%)
- Monitoring and evaluation activities to measure the achievement of program goals and gauge effectiveness. (89.2%)
- Continuing interdisciplinary education to promote effective drug court planning, implementation, and operations. (86.5%)

- Forged partnerships among drug courts, public agencies, and community-based organizations that generates local support and enhances drug court effectiveness. (91.9%)

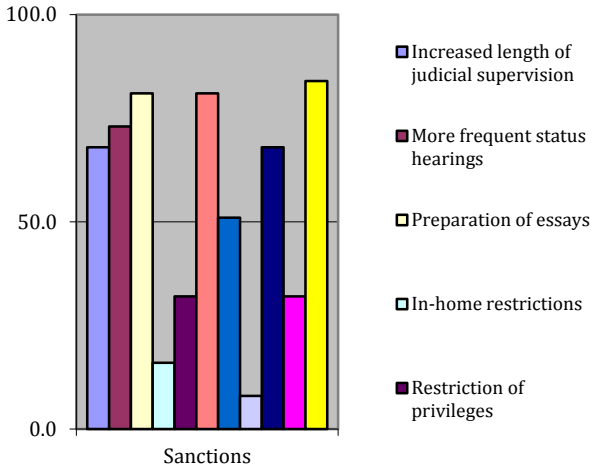
DDCs utilize a diverse set of criteria to define participant eligibility for their programs. The most common criteria utilized by survey respondents are summarized below:

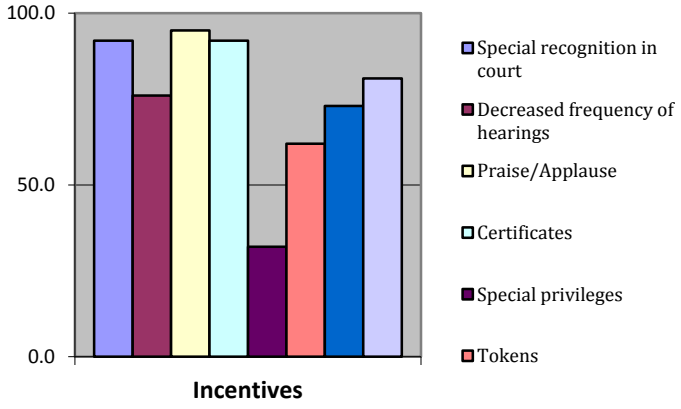


With regard to the criterion of abstinence from alcohol and other drugs, a number of survey responders indicated that this was not required for participant entry into the program, but was expected to be accepted as a condition of program compliance. Other criteria (including exclusionary) noted by survey respondents included:

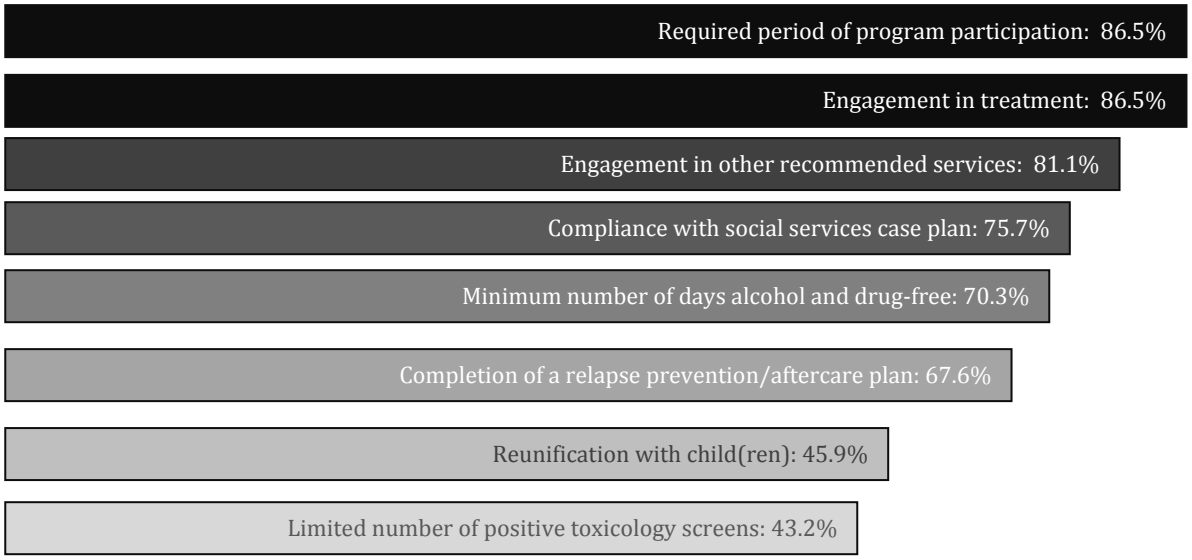
- Age of children: some courts are focused on parents of children ages 0-3 years, parents of children born with positive toxicology screens and/or drug exposed;
- No serious mental health issues;
- No serious violence perpetration issues/cannot be a violent offender or registered sex offender;
- No history of physical or sexual child abuse;
- No history of long-term incarceration;
- Program participation of spouse (sometimes waived).

All DDC programs utilize a set of program incentives that are employed to reinforce the positive behavior and progress of participants, and a set of sanctions that serve as a consequence for program non-compliance and negative behavior. Survey respondents report use of the following sanctions and incentives:





As with criteria for eligibility, DDCs vary in terms of the criteria they establish for successful program completion. **Successful treatment completion** is the factor that is most shared by the most programs (95%) as a requirement for graduation, followed by:



In addition to the above criteria, a number of survey respondents require participants to be involved in 12-step meetings, secure sober housing, and have a plan for self-sufficiency.

SERVICES AND RESOURCES

The majority of DDCs surveyed indicate that they contract with one or more service providers in order to ensure that participants' needs are met related to treatment and supportive services. In many cases, the contracts with treatment providers are managed by the County Alcohol and Drug Program authority or the County Social Services agency. For those DDCs that contract directly with service providers, over half of them contract with 3 or fewer. Two survey respondents have program contracts with 20-25 providers, one program contacts with at least 10 providers, and

approximately 25% contract with between 4-9 providers. For DDC programs that don't contract directly with providers, existing referral networks are most often leveraged to ensure that program participants have access to treatment and other services.

A distinct advantage of engaging in direct contracts with service providers is in having DDC participants prioritized for available treatment slots. 44% of survey respondents acknowledged that clients in their programs have priority access to slots available with contracted providers only, while 26% have priority access to available slots in the jurisdiction whether or not a contract is in place. Approximately 24% are unable to secure priority access for available slots for their program participants.

When asked whether their program participants had sufficient access to treatment, the DDCs responding to the survey indicated that outpatient services were the most readily available, with only 3% noting this level of care as a significant gap in their jurisdiction. In stark contrast, residential services and intensive outpatient services - particularly those that are gender-specific and accommodate children – are in short supply. (See table below). At least one respondent noted that absence of available residential treatment slots for single fathers, and several commented on the impact that the current economic crisis has had on reducing available programs and services and increasing wait lists.

	Sufficient	Insufficient	This is a significant gap
Residential:(child stays with parent)	**55.9% (19)**	23.5% (8)	20.6% (7)
Residential: gender-specific	**60.6% (20)**	21.2% (7)	18.2% (6)
Residential: not gender-specific	**56.7% (17)**	26.7% (8)	16.7% (5)
Intensive outpatient/partial hospitalization	**36.4% (12)**	**36.4% (12)**	**27**.3% (9)

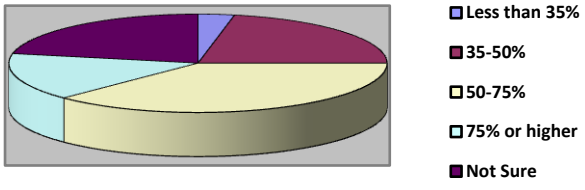
While 70% of DDCs surveyed build in aftercare support for participants following their successful completion of the program, those counties that aren't able to incorporate that as a formal program component attribute this to lack of funding. These programs make active efforts to establish informal alumni groups as well as link former participants with community resources to provide ongoing support.

In addition to treatment for alcohol and other drugs, DDCs indicate that program participants have the highest need for the following services:

- Parenting Education and Transportation ranked highest, with 91.2% indicating these areas as a need;
- Mental Health Treatment and Individual Counseling ranked second highest (85.3%);
- Employment Assistance and Child Care ranked third highest (82.4%); and
- Housing/Rental Assistance and Domestic Violence Support ranked fourth highest (79.4%).

These needs were closely followed by life skills training and family counseling (76.5%), medical/dental/prenatal care and self-help group support (73.5%), and children's services (70.6%). Approximately half to two-thirds of the DDCs identified family preservation services and basic needs support (shelter, cash and food assistance, and clothing assistance) as a need. Slightly less than half identified support in the areas of legal assistance, bilingual services, marriage/couples counseling, and literacy education as needs for their participants, and less than a third of those programs responding to the survey indicated that their participants need services related to disability, debt relief, and respite care.

When asked about their program completion rates, the majority of survey respondents (a little over a third) report that between 50-75% of participants complete their programs successfully.



Program Capacity and Outcomes

Program enrollment among survey respondents ranges from less than 5 families at any given time to over 300 participants (in Riverside County's Family Preservation Court). With few exceptions, most programs are not operating at capacity, as indicated in the table below. The majority report rarely or never having a waiting list for their programs, although slightly over 36% indicate that they maintain a waiting list at least some of the time.

DDC	Total # of Kids Under Court Jurisdiction	Total # of Parents in Dependency Court	Estimated # of Parents Eligible for DDC (rounded)	Able to serve what % of eligible families	Total # of Parents in DDC	Current DDC Capacity
1. Alameda				30-40%	35	Open
2. Contra Costa						
3. Del Norte						
4. El Dorado			30	80-90%	22	25
5. Fresno						
6. Lake			40	20-30%	11	10
7. Los Angeles			2400	>10%	60	120
8. Mendocino						
9. Merced				unknown	24	30
10. Modoc			20	90-100%	3	20
11. Nevada						
12. Orange	2920		260	30-40%	35	90
13. Riverside	4012		370	70-80%	300	276
14. Sacramento						
15. San Benito						
16. San Bernardino	3478		300	20-30%	85	100
17. San Diego	4517	4063	250	40-50%	35	100
18. San Joaquin				80-90%	170	open
19. San Francisco			100	40-50%	20	40
20. San Luis Obispo			80	20-30%	25	25
21. Santa Barbara			30	60-70%	5	20
22. Santa Clara	1608	1491	250	40-50%	133	100
23. Santa Cruz			185	30-40%	45	65
24. Sonoma				unknown	14	15
25. Tehama			35	40-50%	15	15
26. Tuolomne			45	90-100%	40	50
27. Ventura				100%	10	open

Beyond funding limitations and budget cuts, DDC programs cite the following issues as the biggest challenges to their growth and success:

- Limits to judicial participation and availability;
- Lack of housing and employment opportunities for participants;
- Insufficient time and staffing to provide more intensive judicial case supervision;
- Lack of buy-in/limited understanding of the collaborative court process from child welfare, attorneys and dependency court community;
- Insufficient treatment options or choice of treatment providers;
- Inconsistent staffing assigned to the DDC docket;
- Inadequate access to data from the CPS system for evaluation and reporting purposes; and
- Incapacity to accept more families into the specialized court docket.

"The program is instrumental in helping families overcome barriers to reunification. One of our strengths is the success of the collaborative unit. Program services are driven by the client and guided by the drug court team. The program has changed the way we look at these cases and has saved the County valuable resources and funding."

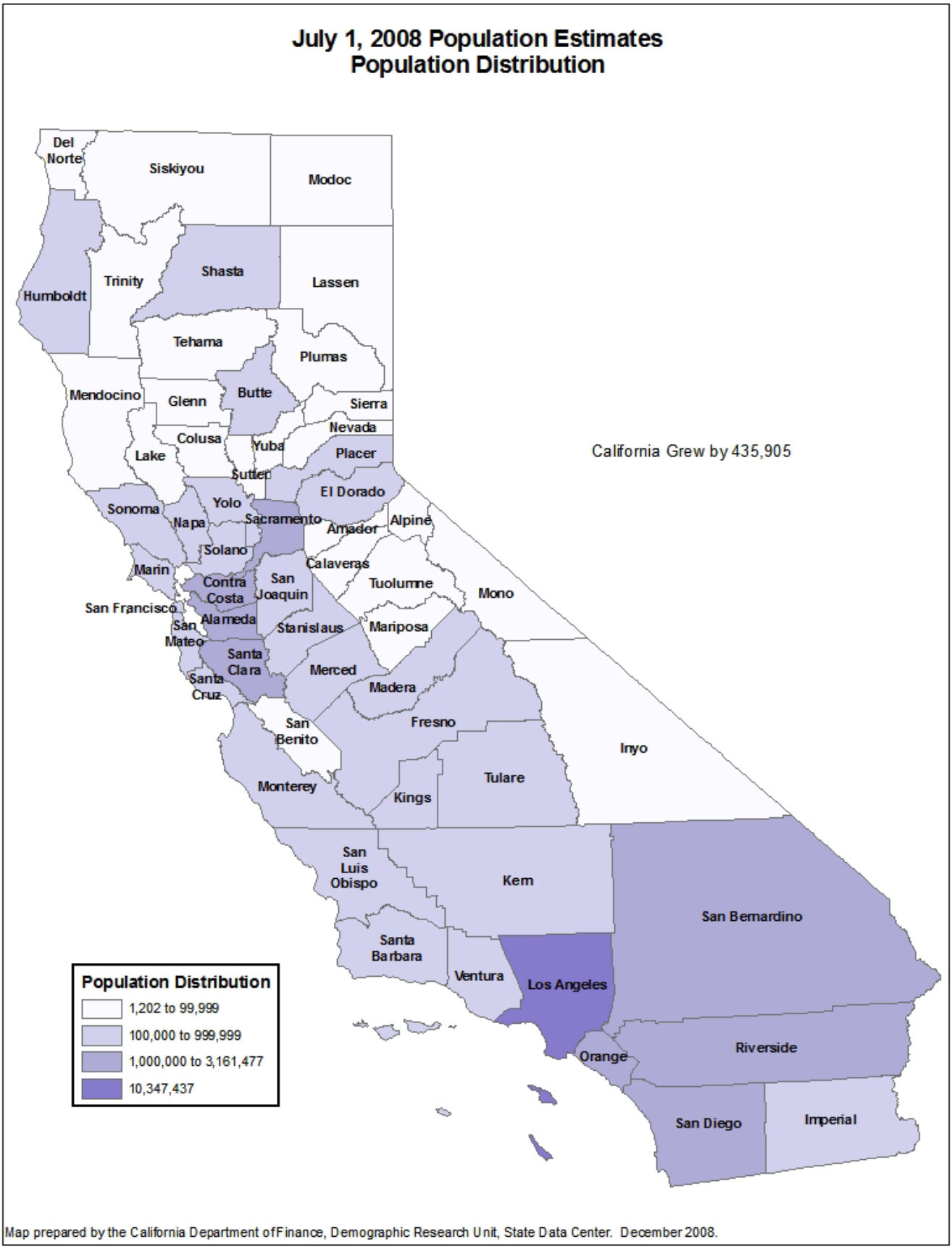
In spite of those challenges, the DDCs responding to the surveys were able to articulate a number of strengths that set their programs apart, including:

- Respectful, individualized treatment of participants
- Continuity of stakeholders and judicial commitment
- Treatment and Case Management
- Caring judge and staff
- Smaller caseloads
- Better outcomes
- Frequent judicial review
- Collaborative model: team support/approach
- Program structure, cross-agency communication
- Quality of treatment providers and use of best-practice services
- Community support and collaborative partnerships with other providers and agencies

When asked which resources would be needed in order for DDC programs to serve all of the eligible cases in their respective jurisdictions, it is no surprise that "*funding*" was the most frequent response, with 91% of the programs selecting that answer among multiple options. When probed further, respondents indicate that more funding is needed to support staffing (social workers, program coordinators, case management), service capacity expansion – especially for children's services and residential treatment slots that accommodate whole families; operating expenses (incentives, drug testing, staff training, etc.); supportive services such as transportation, housing stipends, and health care; and support for planning and evaluation activities.

In addition to an overarching need for technical assistance to help programs put effective data management systems in place, the training needs identified focused on:

- Cross-system teamwork and collaboration
- Improving service delivery and outcomes through the use of evidence-based practice and importing lessons learned from effective models utilized elsewhere
- Topic-specific training (screening and assessment, parenting, theories of addiction, co-occurring disorders, etc)
- Evaluation, data management/monitoring, and program sustainability


July 1, 2008 Population Estimates
Population Distribution
Del Norte
Siskiyou
Modoc
Humboldt
Trinity
Shasta
Lassen
Tehama
Plumas
Mendocino
Glenn
Butte
Sierra
Nevada
Colusa
Yuba
Placer
Lake
Sutter
El Dorado
Sonoma
Yolo
Napa
Sacramento
Amador
Alpine
Solano
Calaveras
Marin
Contra Costa
San Joaquin
Tuolumne
Mono
San Francisco
Alameda
Stanislaus
Mariposa
San Mateo
Santa Clara
Merced
Madera
Santa Cruz
San Benito
Fresno
Inyo
Monterey
Tulare
Kings
San Luis Obispo
Kern
San Bernardino
Santa Barbara
Ventura
Los Angeles
Orange
Riverside
San Diego
Imperial
California Grew by 435,905
Population Distribution
1,202 to 99,999
100,000 to 999,999
1,000,000 to 3,161,477
10,347,437
Map prepared by the California Department of Finance, Demographic Research Unit, State Data Center. December 2008.